Harvard Business Review

CUSTOMER SERVICE

What Has the Biggest Impact on Hospital Readmission Rates

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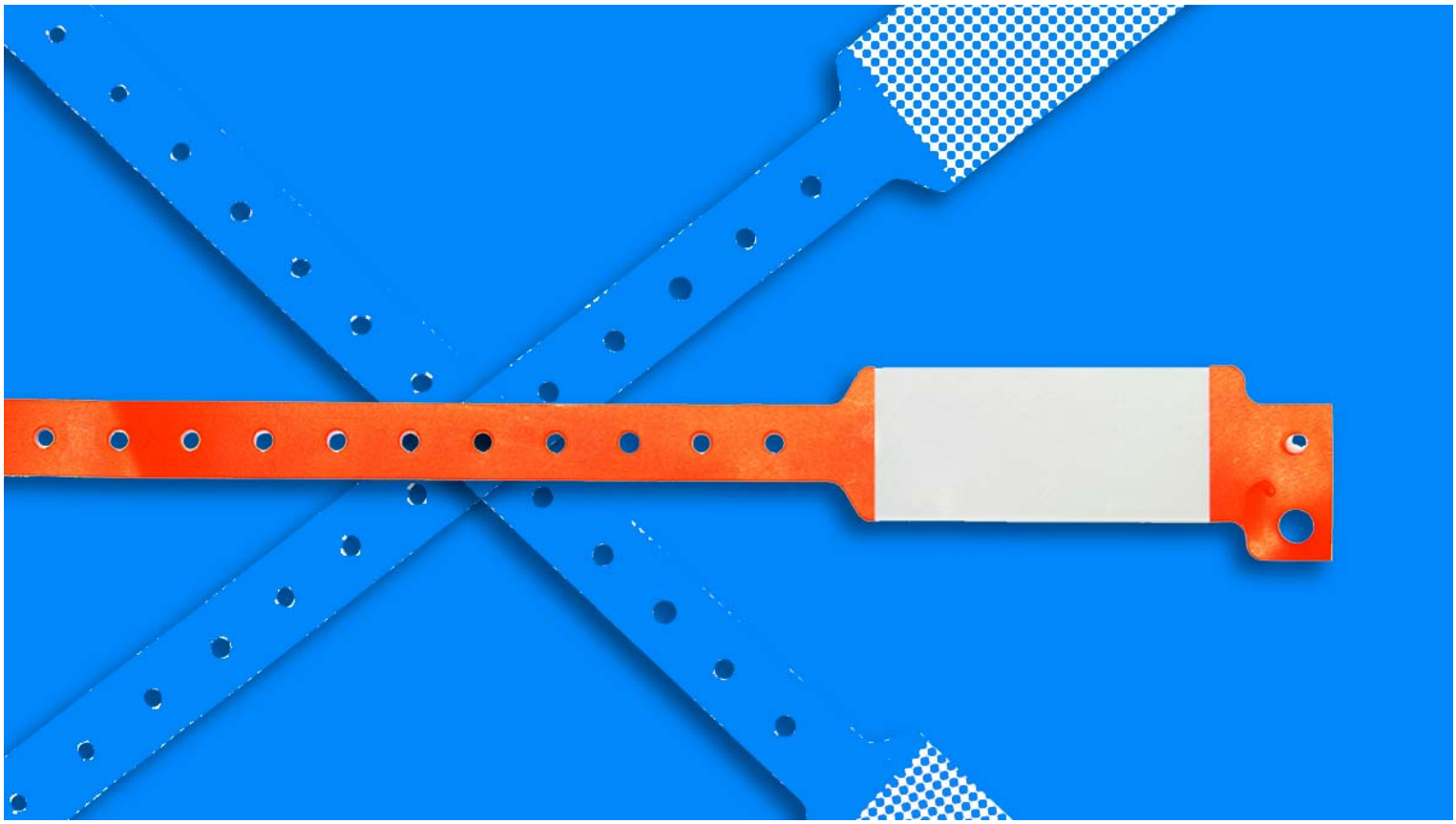
SEPTEMBER 23, 2015



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Health spas, stone fireplaces, and five-star restaurant chefs are amenities typically associated with luxury hotel brands such as The Ritz-Carlton and Four Seasons. They are increasingly found in U.S. hospitals eager to improve their patient-experience scores that now affect Medicare reimbursements. While investing in such material assets is easily done and provides immediate gratification, findings from our research using six years of data from nearly 3,000 acute-care hospitals suggest that it is the communication between caregivers and patients that has the largest

impact on reducing readmissions. In fact, the results indicate that a hospital would, on average, reduce its readmission rate by 5% if it were to prioritize communication with the patients in addition to complying with evidence-based standards of care.

The Centers for Medicare and Medicaid (CMS) and the U.S. Agency for Healthcare Research and Quality (AHRQ) rolled out the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) survey in 2006 to measure standards of hospital care from the patient standpoint. Just two years ago, CMS began to use these survey scores, along with process-of-care measures, to adjust reimbursement rates. The penalty for falling short isn't insignificant. Hospitals risk losing 1.5% of their Medicare reimbursements in Fiscal Year 2015 if they don't show simultaneous improvements in both process of care measures and patient experience. By 2017, that looming cut will grow to 2%, which equates to millions of dollars for an average hospital.

The importance of improving their process-of-care measures is nothing new for hospitals. These measures represent the level of adherence to evidence-based standards of care achieved by the hospitals, as documented on patients' medical records. For example, administering a beta blocker to heart attack patients within 90 minutes of arrival is an established process-of-care measure for a heart attack patient. In 2013, about 96% of eligible heart attack Medicare patients received this basic medication, which means 5,761 patients admitted for heart attack did not. Although it can be expensive to improve the process-of-care measures by standardizing processes, caregivers widely recognize the value given the scientific evidence behind these measures. (In his book, *The Checklist Manifesto*, Atul Gawande shows how using simple tools like checklists can help hospitals improve on their process-of-care measures.)

In comparison, improving patient-experience scores collected through the HCAHPS survey presents tougher problems for hospital administrators. Caregivers typically see these survey measures as "perceptual," "less scientific," and "not useful for improving clinical outcomes." The HCAHPS survey asks the patients to rate their quality of experience during the stay at the hospital. It includes measures such as the extent

of communication with caregivers (i.e., doctors and nurses), the speed of delivery of help, the explanation of procedures, the management of pain, and the post-treatment instructions for recovery. Patients are also asked to rate the hospital environment in terms of cleanliness and quietness in addition to overall satisfaction and their willingness to recommend this hospital. As these questions show, the HCAHPS deals with questions on communication (e.g., quality of caregivers' communications, recovery instructions), and caregivers' ability to respond to patients' explicit needs (e.g., reacting to a patient's call for help), as well as hospital ambience and general questions (e.g., Was the hospital clean and quiet? Was it a best or worst hospital stay?). In 2013, only 71% of the patients surveyed highly rated their recent hospital experience. The bottom line: Hospitals have long ways to go in their journey to improve the patient experience.

Faced with the ultimatum from CMS in their recent value-based-purchasing reform, hospitals are rethinking their strategies to improve their HCAHPS scores aimed at measuring patient experience. Many are doing so by investing in superficial amenities or by investing in technologies that allow caregivers to track and respond to a patient's call for help. This is certainly not a bad idea given the cultural difficulties involved in changing their caregivers' mindset to improve their interpersonal communication skills. But will all these material assets substitute for a change in culture and solve the problems in the delivery of care? Our research suggests they won't.

In an article being published in *Management Science*, we examined whether improving two different dimensions of patient experience measured using HCAHPS scores and process of care measures impact hospital readmissions. The *communication-focused* dimension corresponds to the caregiver's ability to engage in meaningful conversations with the patient. The *response-focused* dimension corresponds to the caregiver's ability to respond quickly to a patient's explicit needs. Improving these dimensions require different hospital resources: While the response-focused dimension benefits from investments in things like visual monitoring systems and RFID location systems, the communication-focused dimension benefits from training programs that teach interpersonal skills and empathy to caregivers.

Our research examined the relationship between these patient-experience dimensions, the process of care, and a hospital's performance in terms of readmissions and operating costs. We supplemented our analyses with in-depth case studies of five acute-care hospitals that involved close to 50 semi-structured interviews with hospital administrators, physicians, and nurses.

Results from these efforts collectively suggest that when the process-of-care quality is high, improving on the communication-focused dimension has a much stronger effect on reducing readmission rates when compared to improving on the response-focused patient-experience dimension. In fact, the communication-focused dimension and process-of-care combo results in a 5-percentage-point reduction in 30-day readmission rates for an average U.S. hospital. The reduction is just under 3 percentage points for the response focus and process of care combo. The net difference of over 2 percentage points for an average hospital is a conservative estimate and compares results for only a 1% increase in the each patient experience dimension.

If these results are that powerful, why aren't hospitals focusing on improving this patient experience dimension? The answer is that improving the communication-focused dimension involve significant training costs, in no small part because health care traditionally has focused on the evidence-based process of care rather than the patient experience. This bias is reflected in medical education, which teaches technical skills to caregivers and puts relatively little emphasis on the importance of interacting with the patient.

Thus, while investing in cultural change represents a daunting task for hospitals, investing in amenities might appear to be an attractive alternative. Interestingly enough, our research shows that, when process-of-care quality is high, improving the communication-focused dimension of the patient experience is less expensive ($48 per patient discharged from an average U.S. hospital for a one-percentage-point increase in patient-experience scores) than improving the response-focus dimension ($62 per patient discharged from an average U.S. hospital for a one-percentage-point increase in patient-experience scores).

These results present an interesting cost-quality tradeoff for U.S. hospitals. While it is generally costly for hospitals to improve the patient experience, these costs are lower and the benefits are also higher if, in combination with a high-quality process of care, the focus is directed at improving communication between caregivers and patients. This has a dual punch of not only being less expensive but also far superior in reducing readmissions. These results have important implications for where hospital administrators should invest to improve the overall health-care-delivery system in the United States.

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ANBHANJI Bhanji 35 minutes ago

Thank you for your article. While I appreciate that communicating treatment and follow up is important, did you study evaluate the post-hospitalization care that patients received (or didn't receive) as a factor in re-admissions? For example, having a care navigator or case manager in conjunction with a primary care provider who is following up on a care plan developed in the hospital would likely provide higher quality care for complex populations who tend to bounce in and out of hospital.

Secondly, has your research looked into patient-reported experience and outcome measures in real-time as a better gauge of their experience rather than a post-stay survey such as HCAHPS?

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